

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2026  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  |                                                                                          |                                                                                                                          |                                                        |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355063</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>03 - MAIN BUILDING</b><br><br>B. WING _____ |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/21/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST LUKES HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>242 10TH ST W<br/>DICKINSON, ND 58601</b>    |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |  | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| K 000                                                    | <p><b>INITIAL COMMENTS</b></p> <p>This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b).</p> <p>The St. Luke's Home was located in a two-story building of Type II (111) construction and a one-story building of Type II (000) construction. A two-hour fire resistance rated construction barrier provided separation between the two-story building and the one-story building. The building was protected throughout by a wet/dry automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>A two-hour fire resistance rated occupancy barrier provided separation to an apartment building to the northeast.</p> <p>Note:<br/>Observation and records review determined the facility to be in compliance with the minimum requirements of the 2012 Life Safety Code and the 2012 Health Care Facilities Code.</p> |                                                                            |  | K 000                                                                                    |                                                                                                                          |                                                        |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/25/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355063</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST LUKES HOME</b> |                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>242 10TH ST W<br/>DICKINSON, ND 58601</b>                                    |                            |                                                        |
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| E 000                                                    | Initial Comments<br><br>A recertification survey conducted on 04/21/2025 found St Lukes Home in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness. | E 000                                                                      |                                                                                                                          |                            |                                                        |

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